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ABSTRACT

This report summarizes an evaluation of a 4-week sexual health education program in a disadvantaged, urban target school in Scotland, and the investigation of the longer term impact of a previous 10-week program involving sexual health education provided by health workers. In-depth interviews with 5 boys and 5 girls revealed that the 10-week program was still valued by the students several months later and that sexual health programs taught by people seen as credible by students had an impact on students' health behavior. The primary portion of the project focused on a revised sexual health program that used Personal and Social Education teachers and lasted 4 weeks instead of 10. Results of the study indicated that, given time, resources, and training, teachers could be empowered to deliver effective sexual health programs. Students were highly satisfied with the program, which raised their knowledge of sexual health facts and provided useful decision making skills. They indicated the program changed their perceptions that teachers should not be involved in teaching sexual health. Teachers reported gaining confidence as providers of sexual health education and identified benefits of co-teaching; health workers, however, were somewhat concerned about their lack of input in planning the program. Teachers and health workers agreed that the model had worked well and future programs could be taught just by teachers, with support from health workers. Principal findings of the study include: (1) planning is critical for collaborative sexual health programs; (2) the role of the Health Board in future sexual health programs at the school is essential; (3) Health Boards must be funded to be able to participate in these activities; (4) committed staff is crucial; and (5) the effectiveness of sexual health programs depends to a large extent on the school, its structure, and the commitment of senior school management. Data from the study are reported in the appendices.
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Improving a Sexual Health Education Programme

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Stuart Hall*

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Improving a Sexual Health Education Programme

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**The Scottish Council for
Research in Education**

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A report arising from an evaluation, commissioned by the Greater Glasgow Health Board, of a school sexual health education programme carried out in 1994/95.

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Executive Summary

■ Background

In 1994 SCRE was commissioned by Greater Glasgow Health Board to undertake an evaluation of a revised, four week sexual health education programme in a target school and also to investigate the longer term impact on individuals of the previous ten week programme. The findings are summarised below.

■ Research Area 1: The impact of the earlier programme

One part of the research project involved looking at the previous ten week programme provided by healthworkers. In-depth, qualitative interviews with five boys and five girls randomly selected from S4 provided useful insights on the longer term impact of the school's initial sexual health programme. In particular, these interviews highlighted the processes which affected pupils' decision making concerning sexual health. The main points to emerge were:

- The programme was still valued some months after its delivery by the pupils. Three of the ten pupils said they had been in situations where sexual intercourse had been a possibility or had occurred. The course had actively empowered two of these pupils (one 15 year old boy and a 16 year old girl) in that they made decisions which avoided potential sexual health risks. However, the other pupil, a boy (aged 16 years) said that he would have risked unprotected intercourse if condoms had not been available even though he claimed he had understood the message given by the course concerning this issue.
- The accounts of the ten pupils imply that sexual health programmes which provide knowledge and decision making skills delivered by people seen as credible by pupils and using an approach grounded in trust and approachability, can have a real impact on pupils' health behaviour.
- The findings from this part of the research provided insights into the very complex world of young people where a range of influences including knowledge, understanding, views of peers, sources of information, social settings and gender, interplay to shape their views and behaviour concerning sex and relationships.

■ Research Area 2: An evaluation of the revised sexual health programme

Research Area 2 formed the main part the evaluation of the revised sexual health programme which differed mainly from the previous programme in that it involved PSD teachers in the delivery of the content. The revised programme was also shorter in duration than the previous one, being four weeks rather than ten. The evaluation looked at participants' (pupils, teachers and health workers) views on the effectiveness of the revised, four week programme in terms of meeting the needs of pupils and the school. Particular foci included the gains in pupils' knowledge, their attitudes and behaviour/

decision-making, and general satisfaction with the course. Staffing issues included the impact on teachers' confidence to provide this type of programme. The main findings were:

Overview of the success of the collaborative sexual health programme

- Given time, resources, training, and a negotiated programme, teachers can be 'empowered' to deliver effective sexual health programmes. The skills developed can be transferable to other, non-health related, lessons.

The views of pupils

- High levels of satisfaction with the programme were reported by the pupils. Those pupils who had also experienced the first, ten week sexual health programme (S2, S3 and S4) thought the revised one was poorer but only because it was shorter in duration than the earlier course. However, the revised programme was successful in raising pupils' knowledge of sexual health facts and in providing them with knowledge and skills that they thought would be useful in making sexual health decisions.
- Participation in the programme not only provided relevant sexual health information but also altered pupils' attitudes on how such programmes can be taught. Before pupils experienced the programme most were against the involvement of teachers. After the programme, the views of most pupils had changed to look more favourably on using teachers to provide sexual health programmes. This will assist the school in its development and implementation of a sexual health programme where teachers are the main or only people to teach the content.
- Pupils were satisfied with the content and saw it as relevant to their immediate or likely future needs. However, they felt that more time should have been available to discuss some of the issues which the content had raised.

The views of teachers and health workers

- Perhaps the most striking finding to emerge from the data on teachers and health workers was the growth in confidence of teachers following their involvement with the programme. The growth in teachers' confidence and the positive shift in pupils' attitudes to accept teachers as providers of sexual health education strengthens the case for the future involvement of teachers in delivering the programme.
- Teachers and health workers felt that the programme had worked well. However, both groups identified the need for more training and time to discuss how the programme was working. This included clarifying the roles and tasks the health worker and the teacher would adopt during the programme.
- Benefits and shortfalls of co-teaching were identified. Both parties learned skills and approaches from observing one another. However, differences between health workers and teachers on the criteria for a good lesson, and the potential inhibiting effect of having teachers present for some sessions, were recognised by teachers and health workers.
- The health workers were somewhat concerned about the limited amount of negotiation and input they were able to contribute to the planning of the

programme. In addition, they were also concerned about the number of schools that they were expected to cover.

- Despite some critical comments, the teachers and health workers agreed that the model had worked well and paved the way for a sexual health programme which used only PSD teachers. However, a caveat was that any future programme should be able to draw on the support and advice of the Health Board. This support, teachers felt, should include being able to arrange one-off sessions run by health workers to cover topics teachers felt unable to deliver. In addition, the teachers would greatly value support in identifying suitable teaching materials for use in the school's future sexual health programmes.

■ Main issues and implications

Planning collaborative health programmes

The evaluation highlighted the importance of the planning stage for collaborative sexual health programmes. The main points to emerge were:

- Consideration should be given to building more time into the process for negotiation with collaborating organisations, curriculum development (including the identification of suitable materials and resources) and the adequate training of teachers.
- Often schools and their collaborative partners are working under differing pressures and time-scales and can overlook these factors when planning and time-tabling a programme.

The role of the Health Board in future sexual health programmes at the school

Overwhelmingly, the teachers felt that future sexual health programmes in the school must have some health board support, although, this would not necessarily have to include regular health worker teaching. The points relevant to health board support to emerge from the evaluation are:

- The school envisaged the most useful forms of support would include training, advice, materials and occasional topic or issue based teaching when necessary.
- The time and resources of health boards are limited and the extent to which they can actively support schools is correspondingly affected by their budgets and policies.
- Given that our evaluations of sexual health programmes have highlighted the benefits of collaboration between school and health board, there is a strong case for funding for health boards to enable their continued work in this field.

Staffing issues

The importance of committed staff emerged in the findings and raised some issues for collaborative sexual health programmes. These were:

- When health workers deliver parts of a school-based sexual health programme, adequate numbers of workers should be available. Otherwise small teams will often be involved in much travelling which reduces their contact with individual schools and the time available to set up and build rapport.
- Sexual health programmes could also be affected by the numbers of teachers trained to work on such programmes. For example, if the school had a high turnover of such staff then there could be difficulties in staffing a programme with skilled teachers.

School-based factors affecting sexual health programmes

The effectiveness of sexual health programmes depends to a large extent upon the school, its structure, ethos and internal life. This raises implications for the implementation of effective health education programmes. In particular:

- The commitment of senior school management is extremely important in determining how effective a programme will be. For example, the evaluated programme had the very active support of a deputy head teacher in the school and the PSE and guidance staff. This provided the motivation to take the programme forward and evolve it to suit the needs of the school within the available resources.

1 Background and aims of the research

■ Introduction

The need for sexual health programmes in schools in the UK has gained credence and impetus over the last ten years largely due to the emergence of HIV/AIDS as a threat to health. Also, research has revealed that young people are more likely to be sexually experienced than in the past (Farrell, 1978; Ford and Bowie, 1989; Johnson *et al*, 1994). This research has shown that early intercourse is related to lower social class and educational levels but that this effect is becoming weaker. However, while young people appear to be more likely to be sexually experienced at an earlier age there is no evidence to show that they are more promiscuous (Ford and Morgan, 1989; Bury, 1984; and Wellings and Bradshaw, 1994). There has been little research done on homosexual activity among young people, as a result little is known about this area and the possible needs of young people. A study carried out for the Health Education Authority (MORI, 1990) revealed 6% of 16-19 year olds in the survey were bisexual and 1% said they were homosexual. This might seem a relatively small proportion of young people but it raises the point that pupils in this age group could still have needs that might not be covered in some sexual health curricula.

It seems evident then that there is a need to educate young people about sexual health and provide them with information to make informed decisions which will promote their health. However, there is no consensus on the most appropriate approach and content to use. Differing political, cultural and religious viewpoints create a continuing debate about how best to approach sexual health education in schools. Even when there is clear support for school-based sexual health programmes, numerous approaches can be used.

Schools have attempted to address the issue of sexual health in the curriculum and school in different ways. In some cases schools have enlisted the support of external organisations such as health boards to help them develop suitable programmes. The actual delivery of sexual health programmes can vary in approach. For example, they may be taught using only a school's teachers, or they may use a co-teaching approach with health workers working with teachers in the classroom.

Even when teachers are providing a programme on their own, health boards can still provide considerable support in the form of training, advice, materials and 'one-off' lessons on more sensitive topics. It is interesting that, given the range of approaches, there appears to be little work done on evaluating and comparing the benefits, drawbacks and effectiveness of differing models of sexual health programmes. This lack of evaluation is serious when one considers perhaps the most important issue facing health education and promotion for young people, namely the difference between what young people know about health and how they actually behave. It is therefore relevant to examine the relevance of programmes for young people and to assess whether such programmes meet their needs in the framework of their everyday lives.

The evaluation reported here was conducted as a follow-up study to an earlier evaluation (Lowden and Powney, 1994) carried out in a school which had been working with Greater Glasgow Health Board to provide a sexual health programme. The original sexual health programme, taught only by health workers, had been delivered over a ten week period. While this initial programme was seen as valuable by all concerned, it was recognised that such an intensive programme made too many demands on resources to be sustainable. Future programmes would have to be shorter, have less health worker input and more input from the teaching staff. Initially, both pupils and teachers were anxious about a co-taught programme because it had never been attempted in the school. Teachers were worried about discussing certain topics using language preferred by the pupils. The pupils were anxious about talking about sex in front of teachers. Nevertheless, the staff were sufficiently committed to sexual health education within their school to agree to be involved in co-teaching on a revised, follow-up programme.

The revised nature of the programme meant that questions about the suitability and effectiveness of the approach had to be answered.

■ The evaluation's aims and methodology

To assess the general effectiveness of the revised four-week sexual health programme, Greater Glasgow Health Board commissioned the Scottish Council for Research in Education (SCRE) to conduct an evaluation and also to investigate the longer term impact on individuals of the earlier programme. The two aspects of the evaluation are summarised below:

Research Area 1: The impact of the earlier programme

This strand aimed to provide an indication of the longer-term impact of the first collaborative sexual health programme on a small number of pupils who had participated in this programme when in S3. The impact and effectiveness of the previous sexual health course on pupils was investigated, especially in relation to their decision-making concerning sexual health. In addition, the research attempted to gain an insight into other factors perceived by pupils as influencing their decisions.

The main approach used to investigate this research area was in-depth, face-to-face individual interviews with 10 pupils (5 boys and 5 girls) randomly selected from the year group. The interviews were conducted by a researcher of the same sex as the interviewee and addressed pupils' views on the first programme now that some time had passed and whether the course had helped them in the period since it had ended.

Other information was obtained from questionnaires used as part of the method for Research Area 2. Questions asking pupils to reflect on the first programme and to make comparisons with the revised one, were added to the questionnaires given to those in the sample who had been involved in the first programme.

Research Area 2: The evaluation of the revised sexual health programme

This strand looked at participants' (pupils, teachers and health workers) views on the effectiveness of the revised, four week programme in terms of meeting the needs of pupils and the school. Aspects included the effect on pupils' knowledge, attitudes, behaviour/ decision-making, and general satisfaction with the programme. Staffing issues included teachers' confidence and staff development needs concerning teaching sexual health.

For this area, pupils in one randomly selected PSE class from each year group were given a questionnaire to complete both before and after the programme. In addition, group interviews were used to gather perceptions of two PSE classes from S1 and two from S5. Group interviews were also used to gather the views of all teaching staff and health workers involved with the programme. Further details of the methodology are contained in Appendix 2.

■ Information about the school and the programme

The school

The school has approximately 660 pupils and 60 staff and is situated in a large urban housing estate on the outskirts of Glasgow. It is recognised as an area of multiple disadvantage and is designated by the regional authority as an area for priority treatment. Previous census data (1991) and health board statistics reveal an association between the relatively high proportion of lower social class in this area and poor health of the population. More recent (1993) health board statistics for one of the two postal districts which comprise the area show the number of women under the age of twenty who were having children is far higher than the average for the Greater Glasgow area. Such figures make sexual health programmes in this community particularly relevant.

The revised four week sexual health programme

As with the first sexual health programme, the revised programme was negotiated between the school and health board. The health workers devised a curriculum seen as suitable for each of the respective year groups and was based upon their knowledge of young people's needs obtained from their experience with the first programme as well as from their broader work with young people in this subject area.

For the revised four-week programme, each class received two weeks of joint teaching and two weeks of teacher only teaching. Years 2, 3 and 4 received the programme from October 1994 and years 1 and 5 were taught after Christmas. This differed from the original programme which had lasted ten weeks and used only health workers to teach the content. The range of topics covered were similar to those in the first programme but there was less time to go into them in detail. These topic areas were:

- S1 (1) Talking about sex (2) Puberty and the body (3) Menstruation (4) Young people's opinions on sexual health.
- S2 (1) Where do we learn about relationships? (2) Being a boy and being a girl (3) Media collage (4) Legal issues.
- S3 (1) Language game (2) Contraception (3) Safer sex, HIV and other sexually transmitted diseases (4) Making decisions.
- S4 (1) Pregnancy (2) Assertiveness (3) Negotiating in a relationship (4) Working out what help you need.
- S5 (1) Introduction, video and generating questions (2) Language and our bodies (3) Safer sex and sexual choices (4) Contraception and pregnancy.
- S6 There were only a small number of S6 pupils and these were integrated into S5 classes.

The methods used on the programme were diverse and included lecture with group discussion, demonstrations (contraceptives for S3 onwards) videos, question and answer sessions and worksheets.

■ The health board input

The health worker input referred to throughout the report was provided by Health Promotion Officers who were part of the Youth Team of the *Inequalities in Health Initiative*. This is a section of the Health Promotion Department. These workers were recruited from a range of youth-related backgrounds and work on health programmes in both school and community settings. This allowed the school's programmes to be informed by experience gained in forums such as health work in youth clubs, youth projects and intensive group work.

■ The report

This chapter looks at the findings concerning Research Area 1 in which pupils reviewed the longer term impact of the first sexual health programme provided in the previous year. In Chapter 3 we look at the second and main strand of the project: the evaluation of the revised, four week sexual health programme at the school. Chapter 4 draws together the main issues and implications of this evaluation and related research completed at SCRE.

2 The longer term impact of the initial programme

The initial programme had differed from the follow-up programme in that it lasted ten weeks and was provided solely by health workers from Greater Glasgow Health Board. Also, it was taught only to S1, S2 and S3 year groups. The later, revised programme was four weeks in duration, taught to all year groups and used teachers to deliver the content, both alongside health workers and on their own.

The sources of information used to assess the longer term impact of the initial programme were described in the previous chapter. Although the number of informants was small, this strand of the research provided valuable insights into how young people made decisions regarding sexual health and the range of factors influencing them within the context of their everyday lives.

The interviews with the 10 pupils worked reasonably well in eliciting the information needed to inform Research Area 1. However, it was recognised by the researchers that it was more difficult to get boys to talk in depth about their experiences and views even when interviewed by a person of the same sex. The girls appeared more willing to talk about the topic and issues in detail with their female interviewer. They seemed used to talking with their peers about these topics and related experiences. However, as each interview with the boys proceeded they began to talk more freely and a longer session might have been more productive.

The decision to gather information about the previous course only from pupils was in order to see whether or not the pupils at whom the course was aimed, had actually found the programme of real use. Others, such as teachers, would have limited insights to the private world of the pupils. Therefore, the available resources were best used to talk to the pupils themselves. The decision to focus on those who would have been in S3 when they received the programme was based on the previous evaluation which had shown this was often when a transition was occurring in the young people's lives and sexual health decisions were becoming more salient in their relationships.

■ Research Area 1: the findings

The main point to emerge from the interviews with these pupils was that they still felt very positive about the initial programme and the information it had given them.

Pupils' general reflections on the initial programme

All the pupils said that the informal, non-judgmental, and humorous teaching approach used by the health workers had made the programme very interesting and easy to learn. Only one boy said that teachers' presence might have been beneficial. He pointed out that teachers would have brought more of an element of control to the programme; he felt that one or two of the classes had become a little 'unruly'.

All the pupils remembered key aspects of the programme. These included information about HIV/AIDS and sexually transmitted diseases (STDs) in general, the range of

contraception and implications about their use, and body changes in that order. In discussions about the relevance of the programme to their lives, the girls demonstrated that they were quite knowledgeable about the menstrual cycle and fertility and ascribed this to the information gained from their course.

Although the first programme had lasted ten weeks, pupils thought that even more discussion could have been incorporated on safer sex and how to 'make the right choices'. The decision making component of the programme was valued but girls in particular said that more input on how to assess others' intentions, and assertiveness, would have been useful. The knowledge provided on topics such as pregnancy and STDs appears to have influenced these pupils' views on how they would act in sexual situations. Pupils stressed that they saw the importance of using condoms or avoiding sex if they felt in any way unsure about the safety of their actions.

The content of the programme which related to relationships had been particularly valued by the girls. They claimed it had affected how they would make decisions in this area. For example, one girl said she had not really thought about the fact that boys might say that they loved you just to get their own way. Two of the boys and one girl said that mixed sex discussion groups could work when talking about relationships because boys and girls could hear each others' views and reasoning. This, it was felt, could reduce some of the stereotyping, used by their peers such as calling people 'tight' or a 'slag' on the basis of alleged sexual behaviour of particular pupils.

Pupils dealing with sexual situations

Once rapport had been established, the interview focused on whether they had used any of the information or advice from the first programme. Of the ten pupils two boys and one girl said they had been in situations where sexual intercourse was a possibility. These pupils felt that the knowledge and skills picked up from the initial programme had helped them make decisions. The remaining seven pupils said that they had not been in such situations. Nevertheless, they claimed that what they learned from the programme would still be useful to them in the future as they saw themselves at an age where sexual relationships were likely to become an increasingly important part of their lives.

The three pupils who had 'actively' used information or skills gained from the first programme provided insights to how it had affected their decision making concerning sexual situations. One girl whose boy friend had wanted to take things further sexually had decided not to. This girl demonstrated the impact of the initial course on her decision making when she said:

Yes I went out with a boy and he wanted to go further and that came in handy. Like if I hadn't got it (the initial programme) I might have agreed to it. But I didn't and I think I did the right thing because we split up a week later.

When asked which parts of the course had been instrumental in shaping her decision she replied

One of the situations was about a lassie getting pressured from a boy and you had multiple choice answers and the parts on AIDS....and how easy it is to become pregnant.
S4 girl (aged 16)

The two boys who said that they had been in situations where sex was a likelihood, said that the course had affected how they acted. One said,

I was in one situation where I didn't have a condom so I didn't have sex. I waited 'till I did get one.
S4 boy (aged 15)

This boy said that the decision to wait until he had a condom was his and not his partner's. He felt confident that he was doing the right thing. He had thought about what the programme had taught him about the risks including pregnancy and STDs. He claimed that the course had been a very important influence on him. Since the course he has carried condoms which he obtained free from the local health centre. He had found out about this service from the programme.

The other boy (aged 16) recounted an instance where even though he felt the initial sexual health programme had been very informative and well taught, other factors also contributed to decision making. This pupil told of an incident where a group of pupils had met girls from another school on an outing. He said that when it was clear that they would have the opportunity to have sex, one of the boys had gone to the public toilets to get condoms. However, he admitted that he would have still gone ahead with sexual intercourse even if he had not been able to get a condom. His reasoning was that the girls appeared 'keen and you have to take the chance when you get it'. As it happened, the boy and his friends were able to acquire and use condoms.

This boy claimed that his attitude on sexual health had been more serious since the programme and he was clear about the risks of unprotected sex such as AIDS. Nevertheless, in this instance, he still would have gone ahead with sex without a condom. This apparent contradiction could be a cause for concern for those who provide sexual health education, and demonstrates that other strong forces act on young people in these situations. In this case the overriding factor was not what he had learned and his concern about picking up diseases but rather the presence of apparently 'keen' sexual partners. Unlike the account of the other S4 boy, this incident was set within a social context involving several peers. The presence of his friends and a group of girls were additional influences on his decision

What else influenced pupils' sexual health decisions?

Factors other than the sexual health programme were identified in the interviews as affecting pupils' knowledge and decision making about sex. Talking to older family members and friends about their experiences was reported as helpful; three of the girls mentioned that talking to people they knew who were young mothers had made them determined not to become teenage mothers. Magazines were also an influential source of information and advice for the girls and to a lesser extent soap operas such as *Neighbours* were said to have influenced their decisions.

On the soap operas you can always pick things up from them like relationships and what age to do it at or that you're too young to get into a relationship [ie involving sex] like that at our age.
S4 girl (aged 15)

This quote highlights the potential importance of the media as a source of information and in providing role models for young people. Many young people might be able to identify with the content of soap operas, which may contribute to their appeal. Given the apparent relevance of television dramas and soap operas to young people's lives and if other sources of information on sexual health and relationships are absent or less credible then it is not surprising pupils will use the mass media to help them make sense of their world.

Pupils were aware that a lot of information about healthy decisions makes sense in the classroom but decisions can be clouded when in different social situations and contexts, for example, being on holiday, or at parties, especially if alcoholic drink is present. Indeed the pupils said that those friends who had claimed to have had sexual intercourse had used the excuse that they had been drinking that night. Therefore, pupils thought that sexual health courses should look closely at the effects of alcohol on decision making concerning sex. Some of the girls mentioned strategies they had used to help them in such situations such as going to parties with close friends who would 'keep an eye on you' so that they would avoid 'tricky situations'.

If you're going to a party and you know you're going to be drinking you get someone to keep an eye on you to see that you don't disappear into any rooms.

S4 Girl (aged 16)

Other insights into the effectiveness of the first sexual health programme

In addition to the ten face-to face interviews, we obtained further information on the longer-term impact of the initial collaborative sexual health programme from some questions built in to the questionnaire used primarily to collect information on Research Area 2.

A minority of S2 pupils (12%) reported actively using the information they had learned on the initial sexual health programme. Twenty five percent of S3 pupils and 29% of S4 pupils felt that they had used information that they had learned on the course. However only a very small number of pupils (4) completed the open-ended part of the question which asked them how they had used what they had learned on the first programme. From those responses which were provided, we found that three S3 boys and a S4 girl said they had used the information to practice safer sex. The other pupil, a girl in S4 (different to the one interviewed face-to-face), had used skills learned on the initial course to be more assertive in avoiding a situation where a partner wanted sex.

The increased usage of information from the course by older year groups may be attributable to the pupils encountering more situations where a knowledge of sex and sexual health is needed. Differences between the year groups using information from the course may also reflect the different course content presented to the year groups.

■ Conclusions to emerge from Research Area 1

While we talked to only 10 pupils in total, the information provided has given some useful insights into the longer term impact of the initial programme and the processes which affect pupils decision making concerning sexual health. The programme was still valued some months after its delivery and had actively shaped the decisions of pupils who had found themselves in sexual situations. However, we also know that one pupil, a boy, who said he had been in a sexual situation did not appear to have heeded some important messages from the programme concerning unprotected sex. If condoms had not been available he would have risked unprotected intercourse even though he claimed he had understood the message given by the course concerning this issue.

The accounts of these pupils suggest that sexual health programmes which provide knowledge and skills delivered by people seen as credible and using an approach grounded in trust and approachability can have a real impact on pupils' health behaviour. Their information has also provided glimpses of a very complex world where a range of influences including knowledge, understanding, peer factors, wider sources of information, social settings and gender, interplay to shape their views and behaviour concerning sex and relationships.

3 The revised sexual health programme

The second and main research area of the project was an evaluation of the revised four-week sexual health programme at the school described in the first chapters together with the methods of investigation. Information was collected through questionnaires from pupils in S1-S6 but the relatively small numbers involved in each of the Personal and Social Education (PSE) classes limited the type of analysis that could be performed. For example, making comparisons between pupil year groups has to be done with caution because the numbers of pupils in each PSE class never exceeded 25. The resulting cell sizes for statistical analysis at this level were often too small to identify significant differences. The questionnaires were supplemented with group interviews with two groups from S1 and two from S5 and we have arranged the findings into those to have emerged from evidence gathered before the programme started and information gathered after the programme ended.

■ The views of pupils before the programme began

Before the revised programme started pupils, teachers and health workers were looking forward to the programme but, as we shall see, all had their own concerns.

What did pupils hope to learn about from the programme?

The views of pupils gathered before the programme were characterised by their apparent thirst for knowledge on sexual health and anxieties about having teachers provide the course. As we shall see these views underwent a considerable turnabout. Before their programme started, most pupils said that they wanted the course to tell them about safer sex - 48% (40 pupils). Among the girls, the second and third most popular answers were to learn about pregnancy - 23% (11 pupils) and development (21%). The second and third most popular responses among the boys were, sex and sexual health generally - 20% (7 pupils) and sexual techniques (14%).

The most popular reasons given for why the pupils wanted to learn about certain topics was to help them make future decisions - 65% (55 pupils). The second most popular answer (21%) was that they were curious to learn about the subject area and a minority of pupils - 11% (9 pupils) said that they needed information to help them make decisions now. In providing a rationale for their replies in the open-ended section of this question, these nine pupils expanded their answer to indicate that they were already in situations where sexual behaviour (including intercourse) was occurring or very likely to occur. Therefore, the programme was particularly anticipated by these individuals in the hope that it would address their needs and concerns. This group of nine pupils consisted of two boys and two girls from S1, a boy and girl from S3, two girls in S4, and a boy in S6.

In general, the pupils were looking forward to the programme and 80% had no anxieties about their involvement in the course. The remaining 20% who had some worries about the course were concerned mainly about the possibility of 'looking stupid'

if they were involved in a discussion and it became evident they lacked certain sexual health knowledge or experience.

The findings from the group interviews with pupils from S1 and S5 echoed very closely the pupils' questionnaire responses. Information provided by the girls in group interviews was much more detailed and allowed greater insights into their reasons for wanting the programmes to cover certain topics and into what influenced their thinking and actions.

Perhaps not surprisingly, first year pupils were interested in body changes, specifically about what constituted 'normal development'. All of the girls in group interviews seemed to be very eager to learn about a whole range of sexual issues and facts including sexual orientation and the biology and feelings of the opposite sex. This apparent difference may be due to the fact that the girls were more willing than the boys to talk in detail. The most important areas to help S1 and S5 girls were how to decide when it was right to have sex, what type of contraception to use, and how to deal with tricky relationship issues such as telling a partner the relationship was over.

The S1 and S5 boy and girl groups stressed that, ideally, programmes should be frank in their delivery, provided by strangers of the same sex who had expertise, would ensure confidentiality, use same sex groups, and last around six to eight weeks.

Who did the pupils want to teach the course?

Before the programme started, the majority of pupils - 84% (73 pupils) said that they wanted only a health worker to teach the course. Ten percent said that they wanted both a teacher and health worker. This comprised 19% (7) of boys and 4% (2) of the girls. This suggests that girls were more anxious about having teachers present during classes. These findings are comparable with the views of pupils in the school obtained during the evaluation of the initial programme. In our earlier study at the school, the majority of pupils felt that teachers should not teach sexual health because they were seen as not being experts in the subject; they were potentially judgmental and could not ensure confidentiality. The same concerns existed before the start of the revised programme.

The most popular reported reason for preferring a health worker to teach the revised course - 29% (26 pupils) was the perceived teaching style which was expected to be informal and varied. Twenty six percent of pupils preferred a health worker because they were perceived to have a greater knowledge of the subject area. Concerns over confidentiality emerged with 25% (29) of the pupils giving this as their main reason for wanting a health worker to teach all of the programme. The pupils usually held the view that because the health worker was an outsider and did not know them, then they were more relaxed about talking about sexual health topics and issues.

Sources of information about sex and sexual health

Pupils were asked about where they obtained information and advice on sexual health. The most common response on sources of information about sexual health was the pupils' own school - 54% (54 pupils) closely followed by friends and magazines both with 51%. While the figures for boys and girls were similar with respect to the school and friends, they differed more substantially in the use of magazines as information sources. Fifty eight percent (31) of girls and 39% (18) of boys mentioned using magazines for information. Parents were mentioned by only 19% (9) of boys but 58% of the girls said they were sources of information. This demonstrates that girls appear more willing than

boys to approach parents about the topic of sex. One could speculate that socialisation and cultural factors play a role in accounting for such differences. However, it was interesting that as both sexes got older they said that they were more reticent about talking to their parents in case their mothers and/or fathers assumed their questioning meant that they must be sexually active.

Pupils' responses to hypothetical sexual health scenarios

Three scenarios were presented to the pupils (S1-S6) in the questionnaire they received before the programme began. The aim of these were to elicit their views on what they would do in certain relationship situations and their reasons for their response. Their responses would also give us another perspective on potential sexual health needs of these pupils. All three scenarios were written to obtain insights on pupils' assertiveness, their views on peer pressure and their decision making processes.

The pupils read each scenario and then using their own words wrote down what they would do in that particular scenario. The second part of the question required them to elaborate on why they gave the answer they did.

Scenario 1

The first scenario was:

You're at the video shop and you meet someone that you've fancied for a long time. You really want to ask them to go out with you but they've never shown any interest in you. What would you do?

We found that S1 and S2 were less likely than other year groups to feel able to approach the person they were interested in. The S3 to S6 pupils were more self assured but the girls were more likely to say they would be embarrassed and, therefore might use a friend to make first contact on their behalf. When the pupils were asked to elaborate on their responses an apparent gender difference emerged. Boys appeared less likely to say they would be embarrassed about approaching someone they liked, their approach was summed up as 'you like them, so why not give it a go? You have nothing to lose'. Were the boys really more confident than girls, or less willing be seen, or admit to themselves, as lacking confidence? Some caution is advised when interpreting respondents' comments concerning sensitive topics and self image.

Scenario 2

The second scenario focused more on peer pressure. It was presented to pupils as:

It's Friday night and you're at a disco with a friend. Your friend tells you that someone there really fancies you and that you should go out with them. You don't like this person but your friend will think you're crazy if you don't go out with them. What would you do?

The pupils' responses to this situation were interesting in that S1 to S3 pupils mainly said they would resist the pressure of friends and would say they did not want to go out with the other person. In adding their rationale, pupils again demonstrated apparent gender differences. Girls from S4 onwards were more likely to consider going with the person as a 'favour' to their friend, especially if it was to maintain the status quo of their relationship with their friend(s). Girls were also more likely to mention that they would talk to the person in question but not take it further. Girls referred to people's feelings. Boys, on the other hand, were more likely to say they would treat the situation as a 'one-night stand'. Again these findings imply that girls, particularly from S4 onwards, are

more likely to consider pleasing others, especially friends, when making decisions in this area.

Scenario 3

The third and final situation asked pupils to focus on a potentially more sexual situation. We asked:

You're at a party and you're talking to someone that you've liked for a long time. After a while this person asks you if you want to go upstairs with them so you both can be alone. What would you do?

The most striking finding was perhaps, that across the 76 pupils who responded to this question, 21% (16 - 5 girls and 11 boys) said they would be interested in going with the other person because of the possibility of having sex. However, this has to be qualified; pupils from S1 to S2, particularly girls, were more likely to say they would not go upstairs with the other person. Using responses from open ended questions, it was found that across all year groups girls were more likely than boys to say their final decision would be based on whether they could gauge 'how far the other person would go' and what their intentions were. For example, they would go upstairs with the person if they could establish what would happen and they were happy with this. The girls also said that whether or not they felt they could trust the person would affect their decision. They were also concerned about whether they could maintain control of such a situation or whether 'things might go too far'.

However, for the eleven boys who said they 'would go upstairs' the situation appeared far more clear-cut. Their rationale was that such an invitation meant that the other person was interested in sex and such an opportunity was not to be missed. Again, this style of reporting by boys could be an exaggeration and they might be treating the scenario more as fantasy than a potential real-life situation.

Nevertheless, the responses should be free of group factors as the information was collected on individual, self-completion questionnaires. Perhaps the boys' responses to this question are more of an indicator of an underlying attitude towards relationships than a true representation of what would happen in such scenarios. For example, we found in the individual interviews with S4 boys, that other factors such as fear of STDs came into play and shaped their actual behaviour in real life situations they had experienced. Their actual behaviour seemed more considered than the care-free 'go for it' approach espoused in response to our hypothetical scenarios.

■ **Teacher and health worker experiences and views before the programme started**

Semi-structured group interviews and questionnaires were used to gather the views of the nine teachers and six health workers who would participate in the delivery of the programme. The findings are presented as key themes and points of interest related to the main research questions. Using a semi-structured qualitative approach and basing the analysis of teacher and health worker information on their transcripts meant that the findings were relevant to the existing research questions but also allowed unanticipated issues and topics which were salient to the research to emerge. This also enabled the research to obtain contextual information which assisted in the interpretation of comments and the themes which emerged.

Teachers' views about their role prior to the programme

Prior to the programme the teachers were feeling quite optimistic about their involvement in delivering the programme and this was largely due to the training and preparation they had received with the help of the health workers. Before this the teachers had been more apprehensive about any involvement.

However, there were still some concerns among teachers before the programme began. Some teachers expressed anxiety about their role as a teacher and having to adapt it to the style required to teach sexual health. Some feared it could undermine their discipline in the classroom, while others were concerned about confidentiality because their role as school teacher could require them to act on certain disclosures.

Training and support for teachers

The teachers were initially meant to receive two days training from health workers which would focus on using the programme materials, teaching approaches for sensitive topics and any concerns that the teachers had. However, because of time-tabling constraints in the school the teachers were only able to receive one day of training. Nevertheless, this was still seen as a very valuable exercise by teachers and health workers, though one of the main themes to emerge from discussions with teachers included the lack of time available for training. However, it was accepted that the already full school timetable would have made allocating more time to the venture very difficult. The teachers also mentioned that before they started the programme, it would have been helpful to have had more time to read the material they received during training.

Teachers' views on the content of the programme

The teachers were generally supportive of the ethos of the programme and happy with the content which was seen as appropriate for each of the pupil year groups. Information and advice for S1 on contraception and STDs was seen as unsuitable or not necessary by most teachers and should not be covered in any great detail with S1 and S2. This view was mainly based on the assumption that the S1 and S2 pupils would not have any real need of such advice because they were not likely to be involved in sexual intercourse. Before the programme started, however, the pupils in the S1 and S2 groups said they wanted to cover topics which included contraception and STDs. As we have seen, this was mainly based on their intense curiosity and possible anxiety concerning some sexual health topics.

Health workers' general views prior to the programme

As with the teachers, we conducted group interviews with health workers and administered questionnaires before and after the programme. The topics covered the same main research question areas as for the teachers to enable a comparison of health worker findings with teachers.

All six health workers were looking forward to working in the school. They were confident that the programme would work well and that the teachers would meet the challenge of their new role. However, like the teachers, they felt that more time should have been available to plan and train for the programme. In particular, health workers were concerned that there was insufficient time to debrief and discuss after lessons and to build up rapport with teachers and classes. An important area of training which had been skimmed over, or were missing, concerned how teachers could work with groups in some of the more sensitive or complex sessions. The only other main concern about

the programme was, as we shall see, the possibility that pupils might feel inhibited in discussing certain topics when a teacher was present.

Those health workers who had been involved with the first sexual health programme felt that pupils who had also experienced this course might be critical of the shorter, revised one because of its shorter duration. Given more time, health workers thought that additional topics could be added to the sexual health curriculum. These were: gender issues (year group not specified); abortion (year group not specified); pregnancy (S3 onwards); confidence and self esteem (year group not specified); drugs and sex (S3 onwards); expectations in relationships (S2 onwards); males and violence (S4 onwards).

Despite these somewhat critical comments, most health workers stressed that they were looking forward to working with colleagues, teachers and pupils to provide a relevant programme. They were generally optimistic about the impact of the programme both on pupils' level of knowledge and also on further improving teachers' skills to provide this type of course in the near future.

■ The views of pupils after the programme

After the programme finished, pupils teachers and health workers were again asked for their views on the programme. The most striking finding was that pupils now appeared far more accepting of teachers to provide sexual health education. The teachers found that the process of actually teaching such subject matter had helped enormously in boosting their confidence in delivering this type of programme.

Pupils general levels of satisfaction with the programme

Having completed the course, the overwhelming majority of pupils were happy with what they had received - 42% (42) of pupils felt very happy with the course, 52% were quite happy, while only 6% (6 pupils) were unhappy with the course. There was no sex difference other than the 6% of pupils who reported feeling quite unhappy with the course were all female. They gave this response because they wanted the female health worker to provide the programme for a longer period of time. These six girls were not objecting to the programme content as such, rather they had found it so enjoyable that they wanted it to last longer.

When we spoke to the S1 and S5 pupil groups after the programme they said it was relevant to them but both groups suggested that teachers relied too much on the written material and/or video and did not seem willing or able to discuss issues in detail. Obviously, some of the teachers were new to their role of sexual health educator (and possibly uneasy with it); therefore, it seems reasonable to expect them to become more comfortable in talking to pupils and in adapting the material as their experience grows.

The S1 and S5 groups were also similar in that they highlighted the importance of having accurate information to allow them to make sexual health decisions. They wanted future programmes to continue covering methods and skills to help them avoid being pressurised into situations they would prefer to avoid. Such pressure was more often seen as subtle rather than overt. In some cases pupils had derived or constructed certain age related behavioural expectations from a range of sources including their peers and the media.

The S5 groups were more willing to consider some mixed sex discussion groups depending on the topic (for example, discussing relationships). Pupils in S5 agreed that the programme had been useful but some topics such as safe sex and contraception would

have been welcome earlier in their school life. The programme, therefore, would appear, at least in the short term, to be a success in terms of being valued by pupils. It was seen relevant to their sexual health needs and the only criticism related to details on teaching methods and the duration of the programme.

The most important gains as seen by pupils

The most important topics pupils felt they had learned about were, safer sex - 37% (32 pupils) followed by body changes and development - 26% (23 pupils) with contraception - 14% (12 pupils) and sexual health in general - 11% (10 pupils) being the next most common responses. There were no sex differences in the pattern of these responses other than the girls feeling that general information about sexual health was the most important topic they learned about.

There were age group differences, although no real surprises, in what pupils thought were the most important things they had learned from the programme. Those in S1 and S2 were more likely to say the most important thing they learned concerned physical and sexual development, - S1: 90% (19 pupils); S2: 36% (4 pupils) although the S2 pupils felt that what they had learned about safer sex was equally important to them. Safer sex became the most important aspect of knowledge gained from the programme for the S3 (55%), S5 (58%) and S6 (67%) year groups with contraception being the next most important topic. The importance of safer sex and contraception for these pupils is summarised by one S5 girl

Facts about contraception and diseases you can catch were the most important things I learned because these are things which could affect the rest of your life if the wrong decision is made.

Those in S4 had highlighted information and advice on relationships (30%) and contraception (20%) as being the most important topic they had learned.

Did the course meet pupils' needs for knowledge on sexual health?

There was an approximate match between what the year groups had wanted to learn most from the programme and what they most valued having learned from the programme. Younger pupils had wanted and valued most information on body changes and development. Older year groups, from S3 onwards, wanted to learn most about and appreciated having learning about topics on safer sex and contraception. This would seem to justify the content and nature of the programme curriculum for the majority of pupils.

When the pupils were asked an open question about why they saw these topics as being important to them the most common reply was that it was important to know about sexual health in general - 33% (24 pupils). The boys were concerned with having information about how to practise safe sex but even more of a priority was for using the information to avoid getting a girl pregnant. The girls prioritised having the knowledge to have safe sex and to help them make informed decisions generally. The majority of pupils thought that there were no topics missing from the programme, but many of the pupils said that they would have liked more discussion about the topics covered.

The pupils were positive about the potential usefulness of the information and content provided. Following the programme, 54% (17 boys and 36 girls) of pupils felt that what they had learned would be very useful, 37% (24 boys and 13 girls) saw it as being quite useful, 7% (2 boys 5 girls) of little use and 2% (two males) of no use. All fifth and sixth year pupils felt the course would be very useful or quite useful to them.

How did the pupils rate the way in which the health workers and teachers taught the programme?

Given the strong opinions and feelings of pupils about wanting health workers to deliver the course, it was interesting to see a notable change in views after the programme. The teachers' involvement in the programme was rated as very good by 31% (31 pupils) by 50% as quite good, 13% felt they were quite poor and a further 6% said that they were very poor. The pupils who rated teachers as poor or very poor were spread fairly evenly between males and females, and across year groups. Quotes and open-ended responses on questionnaires such as the following were not uncommon.

Great course, brilliant information, helpful for the future. Well done to the teacher.

S6 girl

A total of 81% of pupils saw the teachers' input as good, suggesting that the actual experience of being in a co-taught class was a more positive experience than pupils had initially expected. Before their experience of a co-taught class, pupils obviously had no evidence on which to base expectations of teachers in such classes. As we shall see from teachers' views on the programme, their anxieties about taking an active role in the programme were also greatly reduced by actually teaching the course.

Pupils, although altering their views on teachers, still saw health workers as being better at providing sexual health education. After the course 63% (62 pupils) rated the health worker's teaching as very good and a further 33% as quite good. Only 2% of pupils felt the health worker was quite poor and a further 2% very poor. These 4% of pupils who rated the health worker as poor or very poor were four S3 females. All of these pupils had rated the health worker in this way because she had only taught one lesson; they were not really criticising the health worker at all, but rather the duration of the programme which had meant the health workers could not spend longer with pupils.

One barrier to frank and candid communication between pupils and teachers about sexual health was pupils' embarrassment. Pupils from S1 through to S6 often mentioned that they would be inhibited and embarrassed to speak out in front of teachers who knew them and had, pupils thought, certain expectations of them.

She [the teacher] was good but it was embarrassing to talk to your teacher about sex.

S6 girl

The pupils sometimes sensed that teachers also could feel inhibited and embarrassed which lessened the extent to which topics would be discussed.

The teacher explained things very well but held back a little due to embarrassment I think.

S5 boy

Certain approaches by teachers seemed to ameliorate this effect. If teachers demonstrated that they were not being judgmental and were themselves at ease with the topics, then this promoted effective interaction between teacher and pupils.

It was good because she [the teacher] didn't get mad about some of the words we were using. She was relaxed about it all.

S5 girl

It was especially appreciated when teachers were willing to show that they did not expect pupils to sit passively and agree to what was being said.

Teachers were not involved very much but when they were, they did not tell us the facts and just expect us to say 'okay' and agree.

S4 boy

The impact of the revised programme on pupils' general knowledge of sex and sexual health

Using multiple choice questions administered both before and after the programme we found that pupils generally demonstrated an increase in their knowledge of sexual health following the programme. A comparative summary of the relevant findings is provided in Appendix 1. These compare pupils' responses to the multiple choice sexual health questions both before and after the programme.

Their responses to these questions revealed quite high levels of knowledge about body changes and development before receiving the programme with an increase in knowledge after it across all year groups for both males and females. Where exceptions were found (eg S4 girls' knowledge of where sperm is made) this can be explained by the relatively low numbers of pupils in a certain PSE group. This point should be borne in mind when interpreting the results. For example, given the small numbers of pupils in each PSE class, it takes just two or three pupils to answer a question wrongly or say they do not know and the magnitude of percentage differences within a group can appear quite large.

More realistic differences in pupils' sexual health knowledge emerged in relation to responses concerning how pregnancy could occur or be avoided (eg withdrawal or intercourse during a period). The majority of pupils in S5 and S6 who were presented with detailed information on pregnancy and contraception, answered questions about how one could become pregnant, correctly. Among the other years, especially S1 and S2, there was more confusion.

When looking at their knowledge of 'safer sex'. It was found that there was a relatively high level of knowledge among pupils about condoms and their role in preventing STDs. Having completed the course, further increases in knowledge occurred across all year groups for both males and females.

All pupils from S4 onwards correctly answered the question on how one could become infected with HIV/AIDS. Many of those in the S2 and S3 groups also answered the question correctly. From an already high level of knowledge before the programme, the numbers of pupils answering this question correctly further increased following the programme.

Pupils were asked whether people can pass on STDs without knowing it. In the main the boys were more likely to answer this question correctly than the girls. After the course some confusion among pupils over the correct response to this question was still evident.

How did pupils who received the first sexual health programme feel the revised one compared?

Thirty four percent (34 pupils) who had experienced the revised programme thought it was better than the initial one provided in the previous year while 66% felt it was worse. However, if one bears in mind that before the programme started almost all pupils would have preferred the initial approach, then these figures can be seen as progress.

There was a marked difference between the boys and girls. Fifty-one percent of boys (23 pupils) felt that this year's course was worse or much worse than last year's compared to 80% of girls (43 pupils). The most common reason given for the revised course

comparing unfavourably with the previous course was its shorter duration and the subsequent effect on the amount and depth of topics which were covered.

Pupils' thoughts on improving the revised sexual health programme

Suggestions by pupils for improvements to the sexual health programme almost all focused on increasing the duration of the programme to allow fuller discussion of the topics which were covered. Other comments on improvements were few in number and concerned wanting more information on sources of information and advice on sexual health (5th year girls), providing leaflets and free condoms (one S4 girl). Despite these minor criticisms the programme was praised and S5 and S6 pupils in particular commented that they should have had a similar sexual health programme when they were younger because the topics would have been helpful to them. The salience of this type of programme was highlighted when some of the older pupils mentioned that they had friends of the same age as themselves who were now parents.

■ Teacher and health worker views after completing the programme

Following the programme, teachers felt even more confident about delivering the sexual health programme. This growth in confidence was largely ascribed to the quality of training materials received, and the experience gained from their involvement in teaching the programme.

Support and advice from the health board were seen as essential for future programmes. The types of support desired by the teachers from the health board were:

- the production of suitable materials;
- the provision of training;
- advice on which 'off-the-shelf' materials were available and appropriate;
- provision of 'one-off' sessions on topics that teachers thought they were less well suited to teach.

Looking forward, most teachers thought that continual evaluation and discussion about the progress of future programmes should occur. Two teachers highlighted the fact that more consultation with pupils could take place to assess their needs more effectively. The point was also made that training and curriculum planning should be addressed almost a year in advance to allow it to be slotted into the school time table and to be supported by the in-service programme.

It was thought that if pupils from their first year onwards experienced a school culture and ethos where teachers had an active role in sexual health education, this would assist teacher-pupil rapport and trust and, therefore, improve the effectiveness of future programmes.

Both prior and after the programme health workers were still seen by teachers as the most appropriate people to teach the programme, although, this was recognised as being impractical in the long-term. Teachers felt the best option was a programme which used a teacher only or health worker only approach and which lasted five or six weeks. Such a programme should, they felt, use health workers to cover topics teachers felt unable to teach.

The shift to co-teaching lessons was seen by some as disruptive and contributing to a reduced rapport with pupils. However, most informants perceived co-teaching as a

valuable model for sexual health education with a wider applicability - ie. in other PSE subjects such as drugs education, and subjects such as languages and sport. One of the benefits of co-teaching identified by teachers was to reduce the teacher/pupil ratios in classrooms. This could be particularly useful in sessions on more sensitive subjects or where discussion methods were used.

The duration of the programme

All the teachers thought a programme with a minimum duration of five weeks as a suitable time-frame. Some topic areas of the curriculum were seen as requiring more time to cover the issues. For example, teachers felt the assertiveness part of the programme needed two sessions to explore adequately the related content and demonstrate to pupils what assertiveness actually meant and how it affected one's self image and decisions.

The issue of time in general emerged throughout the teachers' comments. The busy timetable and schools' demanding curriculum meant that other aspects of school planning impinged on the amount of time they could use to train for the programme as well as meeting to discuss how it was progressing.

Teachers' views on their role as sexual health educators and the teaching process

Teachers felt that more could have been done to set out what their role was and what the nature of their input would be before the programme began. For example, some teachers were not clear about how active a role they were meant to take when co-teaching. Consequently they felt that more discussion between themselves and the health workers on their respective role and involvement in the programme would have been helpful.

The actual dynamics of co-teaching varied depending on the personalities involved and their perceived role. However, teachers saw no real problems. This was felt to be largely the result of an ability to talk and share views informally with health workers. Indeed, teachers felt that one of the tangible benefits to emerge from co-teaching was in learning how the health workers dealt with various aspects of the programme.

Some teachers said that they felt awkward or unhappy with the terminology and frank language used to discuss parts of the programme with pupils. Others said that the pupils had demonstrated maturity in the way they dealt with the language issue. Teachers also said that more discussion with health workers about ground rules for lessons would help tackle a number of issues including language use, how to raise and discuss sensitive topics, and dealing with situations where a pupil's question seemed based on his or her real experiences.

Health workers' views on completing the programme

The health workers were generally pleased with the programme. In addition to providing sexual health education to pupils, one of the main aims had been to encourage and support the teachers to take on the role of 'group worker in sexual health education'. The programme had been successful in achieving this goal in that teachers felt confident to take a primary teaching role in future sexual health programmes at the school. However, this did not mean that teachers were, or thought they were, experts in this new role. Both parties felt this role was something which would develop and strengthen over time.

Health workers' views on co-teaching

Health workers' expectations about co-teaching were largely realised in that the experience helped teachers develop their skills in working with the detailed sexual health

education with pupils. The health workers were generally happy with how the co-teaching had worked and mentioned that because the teachers were now participating in teaching the programme, there were the following positive effects:

- Many of the teachers' anxieties were dispelled and the programme was demystified for them;
- Teachers could share experiences and develop ideas among themselves on how to tackle the content and any problematic situations which occurred;
- Teachers' subject knowledge was increased;
- The above benefits meant that teachers' confidence to teach sexual health was increased.

The teachers usually let health workers take a lead role in conducting lessons. However, the workers expected that as teachers become more confident through continued involvement in any future programme, the teachers will feel more able to take a more active role in providing the content. Like the teachers, some health workers, felt that with the benefit of hindsight, more clarification and negotiation could have occurred concerning the health worker/teacher responsibilities, role and expectations.

There were distinct advantages in having teachers in classes, the most commonly mentioned being teachers' knowledge of individual pupils which could be used to help develop a conducive group dynamic and group interaction. Class discipline was often easier to maintain when a teacher was present and this encouraged the class to get on with the topic to be covered.

However, less positive effects of teachers' involvement were also mentioned by health workers. Pupils seemed more hesitant when talking about sensitive subjects such as contraception when teachers were present. Also, occasionally, some teachers demonstrated different ideas from health workers about what constituted a good and desirable session. For example, health workers felt that a noisy, boisterous lesson could still be effective if the debate was constructive; however, teachers did not always agree.

Health workers' reasons for the success of the programme

Health workers identified the commitment and motivation of the teachers, support from senior management, and the general ethos of the school as the main contributing factors in the success of the revised programme. These factors had provided a supportive environment for the sexual health programmes that had been collaboratively provided in the school.

Health workers who were involved with the earlier, original programme felt that the pupils they had taught then had retained a lot of information and displayed evidence of increased awareness when they met again on the revised programme. This helped when covering some of the material in the revised programme but was also put forward as an argument for sexual health programmes being provided every year to build upon and reinforce pupils knowledge and skills.

In practice, the actual content of the curriculum for different age groups sometimes had to be improvised or adjusted 'on-the spot' to suit the needs of the pupils. This responsive approach seemed to make the content especially relevant to the pupils which, in turn, positively affected their attention and learning.

While the programme was seen by health workers as being suitable, given the time and resource constraints, they did feel that the long-term success of future teacher-only sexual health programmes would depend greatly on teachers possessing cultural and personal attitudes which were in-line with the overall aims and ethos of the sexual health programme.

Health workers' suggestions on improving the programme

While health workers were positive in their overall evaluations on how the programme had been delivered and its likely impact, they made some comments concerning ways in which the programme could be improved. These were:

- Training for teachers should be longer in duration and include approaches on how to teach topics they saw as more sensitive.
- Health workers and teachers should receive more guidance and training on how to deal with serious disclosures which might emerge from lessons (eg physical or sexual abuse).

The health workers were concerned that they had not been sufficiently involved in the planning and design of the programme. This was mainly because of the relatively little amount of time available for the health board and school to plan a programme. This meant, however, that health workers felt distanced from some of the aims of the programme. Also, in order to staff the programme, health workers who were already working with other schools and programmes were called upon to staff the programme at this school. This had proved stressful because they needed to travel to and from different sites across the Greater Glasgow area to meet their commitments. This also meant they had little set-up time.

The health workers also supplied their views and ideas on some of the broader issues which were salient to the future development of sexual health education in schools. The main points to emerge were:

- Sexual health promotion and education should continue to provide relevant and accurate information to teachers and pupils. Information and knowledge should be integrated with the lifestyles of those concerned to make topics relevant to the real life situations of young people.
- There should be more attention given to dealing with male attitudes and behaviour when providing sexual health education. Some male attitudes were identified as obstructing group processes in class work and training in approaches to overcome this would be useful.
- Any concerns and anxieties teachers have about the content and other aspects of sexual health programmes should be addressed at the planning stage to obtain their support and co-operation and to facilitate teachers' effective involvement with the delivery of the programme.
- Resourcing sexual health programmes is a main concern because it directly affects the scope of health board collaboration and in particular it affects the extent to which health workers can be actively involved in supporting a school.
- Time for training teachers and building rapport with them and pupils is often lacking, therefore, health workers felt the issue of time should be addressed when planning programmes.

- The frequent perception of sex and sexuality as taboo subjects in schools can affect teachers' willingness to become involved in programmes or, if they do, it can limit the extent to which they apply themselves to the delivery of the programme and its ethos.

■ Research Area 2: Conclusion

It is clear that the pupils were very satisfied with the programme with 91% thinking that it would be of use to them. However, those pupils (S2, S3 and S4) who had also experienced the first, ten week sexual health programme thought the revised one compared less favourably in terms of its duration which meant that topics could not be discussed in enough detail. However, the revised programme was successful in raising pupils' knowledge of sexual health facts and in providing them with knowledge and skills that they thought would be useful in making decisions.

One of the most important findings, and one which has implications for the types of programme the school can adopt, was that pupils were quite satisfied with the teachers' co-teaching role and their input into the programme with pupils feeling they could talk about many topics with teachers being present (although the group interviews highlighted some specific criticisms and shortfalls). This picture is in contrast to pupils' views before the programme. Overall pupils gained relevant sexual health information and modified their attitudes on how such programmes can be taught and by whom.

Perhaps the most striking finding to emerge from the data on teachers and health workers was the growth in confidence of teachers following their involvement with the programme. In particular it was their confidence to teach a sexual health programme which was improved through their experience of actually doing this type of work and receiving training. Their experiences contrasted with many of the anxieties they had previously. This must be good news for the Health Board and school especially in view of the fact that the pupils' attitudes toward teachers involvement in the programme moved away from a very negative position to a more positive one. The projected future involvement of teachers in delivering the programme would, therefore, seem to have a solid foundation on which to develop.

Teachers and health workers felt that the programme had worked well. However, they both identified the need for more training and time to discuss how the programme was working. Co-teaching benefits and shortfalls were identified. Both parties learned skills and approaches from observing one another. However, possible differences in criteria on what constitutes a good lesson and the potential inhibiting effect of having teachers present for some sessions was recognised by teachers and health workers. The health workers were somewhat concerned about the limited amount of negotiation and input they were able to contribute to the planning of the programme. In addition, they were also concerned over the number of schools that they were expected to cover. Nevertheless, the model had worked well and paved the way for a teacher only approach with the caveat that any future programme should be able to draw on the support and advice of the Health Board. This support which teachers felt should be available included being able to arrange one-off sessions run by health workers to cover topics teachers felt unable to deliver. In addition, teacher would greatly value support in identifying suitable teaching materials for use on the school's future sexual health programmes.

4 Issues and implications

In this chapter we examine the main issues and implications to arise from the findings of this evaluation. Also, towards the end of the chapter we draw on other school-based health-related research done by the researchers to identify broader health promotion themes and pose questions for those involved in health education and promotion in schools to consider.

■ The issue of planning collaborative health programmes

The design and implementation of the sexual health programme featured prominently in the findings from teachers and health workers. The main points to emerge were:

- Consideration should be given to building more time into the process for negotiation with collaborative organisations, curriculum development and the adequate training of teachers.
- Both the school and the health board could consider a more systematic way of advanced planning for collaborative programmes. The school and the health board both have busy timetables with many competing priorities. This is compounded by the fact that they appear to be unaware of each other's schedules. Also, each partner appears to wait for the other to make first contact to initiate a programme. Consequently, some major decisions and planning concerning the revised programme were addressed close to its implementation. This had implications for the way the health board drew on staff to work on the programme and the health workers' ability to help in preparation.
- When health workers are to be used in delivering parts of a school-based sexual health programme, adequate numbers of workers should be available. This will avoid stretching them too thinly across various programmes and reduce extensive travelling which can both de-motivate workers and reduce their contact with individual schools.
- The evaluation of both the previous programme and the revised programme has helped to illuminate one model for providing sexual health education. The school's experience has shown that collaborative programmes can progress through a negotiated but essentially co-operative stage, to a collaborative stage and finally to a more school/teacher empowered programme where teachers are comfortable in the planning and delivery of sexual health programmes. Our research suggests that even when the latter stage is attained, support and advice from external sources such as the health board will be a key component in the success of programmes.

■ The length of future programmes

The pupils, many of whom had experienced the first and longer (ten week) programme stressed that the revised (four week) programme would have been better if it had been

longer. The teachers and health workers also saw the benefit of a slightly longer programme. The main suggestions to emerge were:

- Teachers in particular said that a minimum duration of five weeks would be a preferred time-scale for sexual health programmes at the school. Pupils said that they would ideally like a programme which lasted between six to eight weeks. While a longer programme would allow more detailed coverage of more complex topics (such as assertiveness), fitting such a programme into the existing timetable might pose certain dilemmas. School timetables are already under considerable pressure from existing curricular priorities.
- Identification of suitable programme materials and resources as well as providing appropriate training for teachers, even if supported by the health board, will also take up time. Schools and collaborating health organisations will have to build this into their planning and timetable.
- Pupils claim that any additional time available for teaching sexual health should be used to allow more discussion of topics covered by the curriculum.

■ **The role of the health board in future sexual health programmes at the school**

Overwhelmingly, the teachers felt that future sexual health programmes in the school must have health board support although, this would not necessarily have to include regular health worker teaching. The relevant implications from the evaluation are:

- The health board input to the programme was greatly valued by the school which stresses that there should be continued support consisting of training, advice, materials and occasional topic or issue based teaching when necessary.
- The time and resources of health boards are limited and the extent to which they can actively support school is correspondingly affected by their budgets and policies. Given that our evaluations of sexual health programmes have highlighted the benefits of collaboration between school and health board, there is a strong case for continued, adequate funding for health boards to maintain their work in this field.
- Health boards with their wide range of commitments and limited funding and resources will face difficult decisions on priorities and the best allocation of funds. This evaluation suggests that investment of time and resources in working with schools is a vital area for health board work. It is difficult to say what the very long term effect will be. However, our evaluations of collaborative programmes over a two and a half year span indicate that the programmes have already helped some young people in making important, informed decisions about their sexual health and sexual behaviour. The programmes, therefore, have contributed to health education and promotion in the community.

■ **Assessing pupils' needs when devising a sexual health programme**

Sexual health programmes should address the known needs of pupils. However any systematic assessment of pupils' sexual health needs may challenge assumptions as well as take up valuable time. Nevertheless, this is an important issue because unless efforts are made to assess pupils' needs, how can providers be confident that their programme is geared to young people's real needs rather than possibly spurious assumptions?

The evaluated programme was based on the assumed needs of pupils as perceived by health board personnel informed by their knowledge and experience of health promotion and education work with young people. Given the general satisfaction reported by pupils with the content it appears that the decisions about content made by health board staff were well founded. However, some issues still remain:

- Our evaluation revealed that all pupils, but particularly those in S1, S2 and S3, have a tremendous 'thirst' for all sexual health information. While our findings reveal most of the younger pupils appear to have little practical need for detailed information, say on contraception, our research (both from this and our previous evaluation) indicates that a very small number of these pupils do have sexual intercourse or are in situations where this behaviour is a distinct possibility. One could ask, therefore, whether the current curriculum is sufficiently responsive to such pupils' needs. One could argue that more has to be done to help identify those pupils who require detailed information ABOUT issues like contraception, especially in the younger year groups, and provide appropriate specific advice and support. However, the practical and ethical, not to mention political, implications of this approach could be considerable.
- One can debate whether younger pupils (S1 and S2) should or should not receive more detailed information on topics such as contraception. Other topics such as body changes and development are more obviously appropriate for these age groups. But our research indicates that when they do not receive the same detail on the subject of contraception as older pupils, they can remain quite confused, even after the programme, about conception and how to prevent it. Such confusion might be seen as harmless or even normal for this age group but for a minority of younger pupils who might face sexual situations this information could be crucial.
- There are problems in identifying what the 'real' needs of pupils are even if one uses their own agenda. For example, how do health education providers decide whether pupils actually need information to help them with situations which they currently face or are likely to experience? Even if pupils with real needs could be identified (for example, those urgently requiring information relating to contraception), how could one tactfully provide them with a suitable curriculum without compromising their confidentiality. Focusing content on certain pupils may label them and draw unwanted attention from others.
- One teacher suggested a 'menu' based curriculum which would allow individual groups of pupils to select suitable topics after discussion with teachers and/or health workers. There could still be practical and resource difficulties in responding to a potentially wide range of needs. However, the range of salient sexual health topics and curriculum already exists in that pupils at the school appear generally happy with the range of topics available but often they seek more detail. Appropriate fine-tuning of content could be done by negotiation with each group of pupils. When health workers have provided classes, this inter-active responsive delivery usually occurs in any case. It would perhaps be more difficult for teachers who are new to their role as sexual health educators to adopt this style immediately.

■ Supporting teachers who provide sexual health education

As already stated, the school felt that for teachers to continue effectively to provide effective sexual health education, assistance from the health board would be necessary for the foreseeable future? We have also looked at the resourcing and funding implications for the health board if such support is to continue. However, there are further justifications for health boards and other relevant organisations to support schools in providing health education particularly in sensitive areas:

- There is still some sensitivity about discussing some aspects of sexual health especially with younger pupils. Often because of teachers' concern about the reaction of some politicians, parents and the media teachers are wary about dealing with some content matter with younger pupils. This highlights the need for suitable back-up, training and guidance for teachers and all those providing sexual health education in schools. When teachers still feel unable to provide education on certain topics even after training then health workers might have to provide one-off classes on such topics.
- A related issue is possible role conflict for teachers when teaching certain areas of health education. The evaluation revealed that some teachers are still concerned that their role relating to their other school duties, such as maintaining discipline, can place them at odds with common practices in health education such as use of common language or slang terms by pupils in sexual health classes. One could argue that teachers feel uncomfortable with slang terminology because it has never been the norm in schools to adopt such language as normal discourse in classrooms. Slang or scatological language have often been seen by teachers and parents as challenging the authority of the teachers. However, the fact is that pupils (and indeed many if not most adults) will not, or cannot, use medically correct terms to discuss sex, and forcing them to do so may make the content of lessons seem irrelevant or threatening.

This apparent problem is not insurmountable as health workers already allow groups to adopt ground rules for discussion (such as agreeing not to use terms which are derogatory or discriminatory). Training may help teachers to develop their already relevant PSE skills further to suit the context of group work in sexual health teaching.

- Teachers can still fear discussing topics because they think it may involve either themselves or pupils having to disclose aspects of personal behaviour. Effective sexual health does not require this and strategies to avoid personal disclosures or dealing with them if they occur are issues which health board expertise and training could address. Schools and those working in health can move towards common guidelines on what to do if more serious issues arise in sexual health education sessions. For example, adopting an appropriate response if a pupil discloses abuse in their discussions. Most professionals would agree that tactful action would have to be initiated but guidelines for action which have commonality across sectors would be extremely useful when collaborative programmes are used.
- Our findings indicate that, given the time, resources, training, and a negotiated programme teachers can be 'empowered' to deliver effective sexual health programmes. The skills developed can also enhance their input in other non-health related lessons.

■ School based factors affecting sexual health programmes

Many factors can affect the effectiveness of health and broader education programmes. These can include socio-economic variables, family background, community as well as the age and sex of individuals. These variables overlap and interplay to affect people's health and other aspects of their lives such as life chances. From our evaluations of health education programmes at this and other schools (Lowden and Powney, 1994, Lowden and Powney, forthcoming) we have been able to see the importance of yet another factor: that of the school, its structure, ethos and internal life. This raises implications for the implementation of effective health education programmes. These are:

- The commitment or otherwise of teachers, and especially senior school management can be extremely important in determining how effective a programme will be. For example, the evaluated programme had the very active support of a deputy head teacher in the school and the PSE and guidance staff. Their enthusiasm for the programme and its aims was evident in their commitment to become involved and work through the development of the programme including continually reviewing their practice and taking an interest in the development and evaluation of the programme. This, in turn, provided the motivation to develop the programme further to suit the needs of the school within the available resources.
- Despite initial anxieties of the teachers about teaching the sexual health programme they supported the move towards a co-teaching and a forthcoming teacher only model. Their confidence has improved markedly since being involved in the actual teaching of the programme. This support for the aims of the programme, their willingness to explore innovative approaches involving them in challenging situations and requiring them to acquire new skills, despite the heavy workload that currently besets teachers is one indicator of the school's positive ethos concerning health promotion for pupils. Schools and those involved in educational policy and research could examine further the role played by school ethos and organisational factors in promoting health and could explore ways of maintaining or enhancing a health orientated school ethos.

■ Towards a more holistic health promotion approach: points for consideration

Our findings from this evaluation, our previous sexual health programme evaluation at the school and our wider health related research allows us to raise some points for consideration by policy makers and practitioners in the fields of health and education concerning developing and promoting effective health education programmes in schools.

- Consideration could be given on how best to promote the aims of health promotion across schools including reinforcing aspects of health as appropriate in other areas of the curriculum and school life.
- We would speculate that at any one stage in the development of sexual health programmes (and indeed other health-related programmes) they are 'fragile' in that pressures from 'significant others' such as parents, politicians, the media or changes in management and teaching staff can impinge on the nature and success of the programme. Support from the school and wider society both morally and practically (ie. willing to invest resources in programmes) is essential for the long term continuation and success of such programmes.

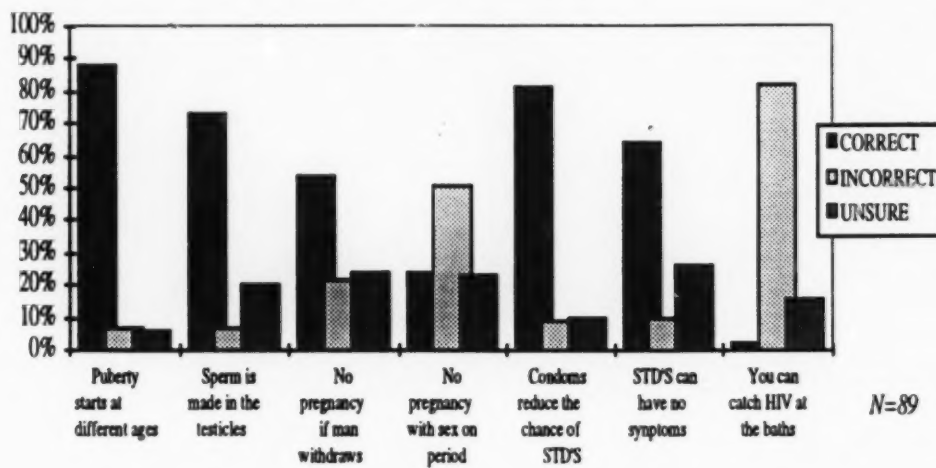
- Sexual health programmes could also be affected by the availability of trained teachers to work on such programmes. For example, if the school had a high turn over of such staff then there could be difficulties in staffing a programme with skilled teachers and this would impact on the quality of the sexual health provision.
- Constant monitoring and feedback (including assessing training needs of educators and the health needs of pupils and gains secured) will assist in maintaining the relevance and quality of programmes. The benefits of such programmes include acting as a catalyst for positive changes in health promotion, communication, and teaching styles in schools.
- The school in this evaluation strives to keep parents informed about curricular developments including health education programmes. As we have already noted, the support of the community and parents for the school and its programmes are vital. If parents are well informed about the aims and rationale for programmes at the outset, it is less likely that misperceptions and anxieties about content will emerge. Other ways to involve parents more actively could also be considered to promote further parental support for specific sexual health programmes. This in turn could help develop closer ties between the school and parents/the community in general.

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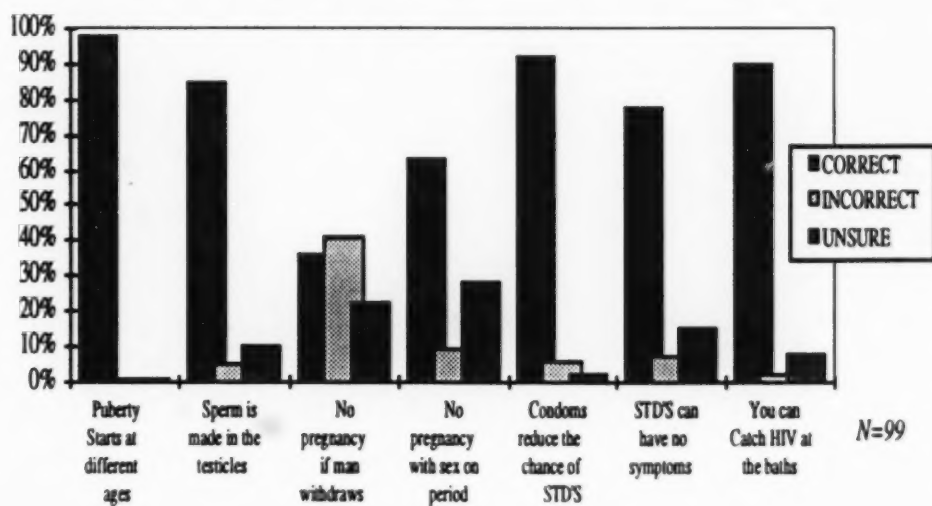
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Appendix 1: Pupils' responses to multiple choice questions

Pre programme responses to multiple choice questions



Post programme responses to multiple choice questions



Appendix 2: Summary of data collection

The approaches and methods used to address the two main research areas are summarised below.

Research Area 1

- This focused on S4 (S3 in 1993) pupils' views on the longer-term impact and effectiveness of the previous sexual health course, particularly on pupils' sexual health knowledge, attitudes but mainly on their decision-making concerning sexual health since the end of that course. Also, what other factors were seen by pupils as influencing their decisions?

Methods

- 10 in-depth interviews with pupils (5 girls and 5 boys) randomly selected from S4.
- Questions included in pupil survey for Research Area 2 (for S2, S3 & S4 pupils) which focused on effectiveness of the previous programme.

Research Area 2

- This gathered participants' views on effectiveness of the revised, four week programme in terms of meeting the needs of pupils and the school. Particular foci included the effect on pupils' knowledge base, attitudes and behaviour/decision-making and general satisfaction with the course. Staffing issues including teachers' confidence in teaching the content.

Methods

- Approximately 20% of pupil population was surveyed using 1 PSE class randomly selected from each year group (S1-S5) to provide representative sample across and within year groups. This gave 89 pupils pre-course and 99 post-course. The difference between the pre and post samples was due to a number of pupils being out of school for work experience during the pre-programme data gathering.

The questionnaires were administered before and after programme with S1 & S5 questionnaires focusing only on revised programme and S2, S3 & S4 questionnaires focusing on revised programme and effectiveness of previous programme.

- Discussion groups with 2 classes from S1 and 2 classes from S5 carried out before and after programme;
- All nine teachers and two health workers involved with the programme completed a questionnaire before and after programme and took part in group interviews after programme.

Response rate to self-completion questionnaires

The table below shows the breakdown of response rate by year and sex for both the pre-programme and post-programme data gathering exercises.

Number of pupils in each year completing questionnaires by age and sex

Year	Males		Females	
S1	7	(9)*	12	
S2	9		12	(9)*
S3	6	(8)*	12	
S4	10	(8)*	6	
S5	—	(7)*	8	(13)*
S6	4		3	(2)*
Totals	36	(45)*	53	(54)*

* Where a different number of pupils completed the post programme questionnaire these figures are displayed in brackets.

The small numbers involved in each of the year groups limited the type of analysis that could be performed with this data. Such small numbers make it very unlikely that tests of significance could prove positive with even substantial differences between years or between the different sexes. It was more useful to look at the quantitative data in terms of the degree of consistency or patterns that were present in the findings.

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